MED - Prior Authorization Work Distribution

Purpose: Distribution of work is completed to facilitate timeliness, access medical expertise and complete tracking with accuracy.

Identification of Roles:

Review Assistant (RA) and /or Review Coordinator (RC) – assigns prior authorization requests in OnBase by entering keywords and forwarding PA to the appropriate RC or RA.

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 calendar days of receipt of the request.

- Complete 95 percent of prior authorization (PA) requests not requiring physician review, and entering them into the system and sending appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, and entering them into the system and sending appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

Path of Business Procedure:

Step 1: The RA and/or RC will log the prior authorization (PA) request on form 470-0829 in the Med 11 logging queue or MED 11 dental logging queue.
Step 2: The RA and/or RC will enter keywords and assign to the appropriate RC.
Step 3: The RA and/or RC will double click the keywords task on the right side of the screen and assign key words:

a. Provider Identification Number (NPI)
b. Member State Identification (SID) Number
c. Type of PA Request
d. PA Sub-type
e. Designated RC

Types of PAs include:

a. 01 Audiology
b. 02 Home Health
c. 03 Vision
d. 04 Dental (including Orthodontics)
e. 05 Durable Medical Equipment (DME)
f. 60 Surgical (including Physician Administered Drugs)
g. 71 Enteral
h. 77 Radiology

Step 4: The OnBase system will auto assign the appropriate PA number from the data entered into the keywords when the RA/RC clicks the "Get #" to the right of PA Number.
Step 5: The PA number consists of a unique ten-digit number composed of the last digit of the year, three-digit Julian date, two-digit PA type number and a four-digit document number (YJJJPA####). For example, 5118030001 would be a PA that was received on April 28, 2005, for a vision PA, and was the first one received for vision on that day.
Step 6: The RA and/or RC will then use the redaction process to enter PA number in Box 12 on the PA form.
Step 7: The RA and/or RC will forward the PA to the designated RC by clicking "Send to RC" to the right under tasks. The PA will go to the Med 11 review queue for completion by the designated RC.
Step 8: This form is located at, http://www.ime.state.ia.us/docs/470-0829.DOC

Forms/Reports:
N/A

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:
N/A

MED - Prior Authorization Eligibility Verification

Purpose: Determination of eligibility prior to authorization review provides enhanced information to providers. Although each authorization will be reviewed for eligibility, approval does not guarantee that member will be eligible at time of services. Provider will access Eligibility Line Verification Service (ELVS) or web portal to verify eligibility at time of service.

Identification of Roles:
RA and/or RC – verifies eligibility of the member prior to using any tasks in OnBase.

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the request.

- Complete 95 percent of prior authorization (PA) requests not requiring physician review, and entering them into the system and sending appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, and entering them into the system and sending appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.
- Urgent requests for prior authorization of services will be reviewed and a decision rendered and communicated in no less than 72 hours from receipt of the request. See Administrative Functions – Urgent Reviews

Path of Business Procedure:

Step 1: Upon receipt of the PA request in the Med 11 review queue, the RA and/or RC will verify member eligibility.

Step 2: Log into Medicaid Management Information System (MMIS).

a. Application Number: Type 10 for recipient eligibility subsystem and press enter.
b. Recipient eligibility file
c. Action Code: Type "I" for inquiry
d. Member ID: Type member's state identification number (SID) and press enter.
e. Recipient Eligibility Display Screen
f. Verify the following:
    1. Member name
    2. Legal name in MMIS matches name on PA form
    3. Date of birth
    4. Some PA types have service limitations based on age
    5. Third Party Liability TPL - IND
        a. If a V or Y is present see TPL resource file below
    6. Eligibility spans
    7. PA start date falls within the beginning and end date span.
    8. Fund codes
        a. Seven (7) and S member is not eligible regardless of date span.
        b. Nine member is only eligible if Q is in the exception indicator field for the same date span press enter.
        c. Fund codes may be reviewed in greater detail by utilizing the DHS system coding instructions manual

http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Master/14-B-App.pdf

9. Recipient Eligibility Display Screen 2
    a. MEDICARE PART A and MEDICARE PART B ELIGIBILITY DATA

10. Recipient Eligibility Display Screen 3 - LONG TERM CARE DATA
11. Aid Type- benefit coverage differs for 501/531 Aid Types. Verify procedure/equipment requested is covered for member's Aid type.
12. See desk guide for specific PA type to determine if long term care (LTC) data (residing in a facility or waiver benefits) effects authorization.
    a. This affects the review of the PA's
13. Patient liability used data
    a. This is not used in determining eligibility for PA. Press enter.
14. Recipient Eligibility Display Screen 4
LOCK-IN DATA, MHAP DATA, IMSACP DATA
    a. This is not used in determining eligibility for PA. Press enter.
15. Recipient Eligibility Display Screen 5
16. HMO Data
    a. If the date span of Health Management Organization (HMO) includes the start date of the PA request, the PA should be returned to the provider with instruction to submit the PA to the HMO provider for review.
17. MediPASS data
    a. This does not affect PA approval.
        1. For services in which a referral is required i.e., surgical the provider will not be paid unless the MediPASS provider made a referral. Press enter.
18. Recipient Eligibility Display Screen 6
19. Guardian data
    a. This does not affect PA approval press page up
20. Third Party Liability (TPL) Resource File
    a. Action Code: Type I for inquiry
    b. Recipient ID: Type Member's SID press enter
21. TPL Resource Display Screen
22. Verify coverage date spans
    a. If start date of PA is within the date span proceed to coverage type (COVER-TYPE).

Step 3: If eligibility conflicts are noted, the RA and/or RC will note the conflict in Box 25 on the PA Request Form using the redaction process. Those responses are:

a. Records indicate that the member has primary insurance that may cover these services. The PA does not override other insurance. Include the explanation of benefits (EOB) from the primary insurance with all claims.

b. Records indicate that this member is covered by a health management organization (HMO). This request for PA must be submitted to the member's HMO provider. Contact the ELVS line at 1-800-338-7752 to identify the HMO provider.
c. Records indicate this member has Medicare. Be advised that obtaining a PA only establishes medical necessity under the Medicaid guidelines. The PA does not override Medicare coverage.
d. Records indicate that this member is not eligible for Medicaid services at this time. Resubmit your request when ELVIS line at 1-800-338-7752 indicates member is eligible.
e. Records indicate this member is on spend-down. Member must meet spend-down to become/remain eligible for Medicaid services.
f. Records indicate member is covered by an Iowa Marketplace Choice Plan. This request must be submitted to the Marketplace Choice Plan provider. Please contact the ELVS line at 1-800-338-7752 to identify the Marketplace Choice plan provider.
g. For 531 Aid type, when not enrolled in an HMO. As stated in box 22, approval is considered only from the standpoint of medical necessity. The provider must establish eligibility at time of service by calling the ELV's line. Also, approval of PA does not guarantee payment if member becomes enrolled with a managed care plan or other commercial coverage prior to service. You will need to contact plan provider to determine approval.
h. The PAs that are denied per Iowa Administrative Code 441-79.9(1) Medicare definitions and policies shall apply. Authorization will to need go through Medicare.
i. When responses (a) or (b) or (d) are utilized, the RA and/or RC will select the appropriate redaction from work flow, redact in Box 25 on the authorization form and select the denial task.
j. The RA and/or RC will select non-adjudicated task and fax or mail authorization to provider.
k. When response (a) is utilized, request review will proceed.
l. If no eligibility conflicts are noted, requested review will proceed.

Forms/Reports:
N/A

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:

N/A

MED - Prior Authorization Durable Medical Equipment

Purpose: PAs are required for some durable medical equipment including enclosed safety beds, insulin infusion pumps, augmentative communication devices, automated medication dispensers, non-preferred diabetic test strips and monitors, wound vacuums, and vest airway clearance systems. Due to the high cost of some items, providers often prefer to secure approval prior to providing equipment to the member.

Identification of Roles:

Review Assistant (RA) – logs PA request in OnBase, assigns PA to RC, sends requests for additional information, sends PA to physician or consultant, returns PA to RC when information returns or when review is back from physician or consultant.

Review Coordinator (RC) – responds to PA requests, checks for duplicate items, screens requests for completeness and reviews for compliance with Medicaid policy, medical necessity, appropriate units, and length of condition and forwards to a peer reviewer when needed.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Physician Reviewer (PR) – external physician reviewing medical records for a variety of reasons

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Consultant Reviewer (CR) – provides determination for authorizations regarding questioned medical necessity.

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the request.

- Complete 95 percent of prior authorization (PA) requests not requiring physician review, and entering them into the system and sending appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, and entering them into the system and sending appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.

- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

Path of Business Procedure:

Step 1: Upon receipt of PA in Review Queue, the RC will review MMIS file 12, PA, by member state identification number (SID) to see if equipment was previously authorized so as to avoid duplication and to see other durable medical equipment (DME) equipment that has been authorized.
Step 2: There are certain DME that is not covered if the member resides in a facility (ICF, ICF/ID or Skilled). Upon eligibility verification, if member is in a facility (ICF, ICF/ID) use denial reason 828 if the item is not payable. Medical equipment is not authorized if member is in a facility unless listed in the exceptions noted in the Provider Manual http://www.dhs.iowa.gov/policyanalysis/PolicyManualPages/PolManual.htm.
Step 3: When checking eligibility in MMIS File 10, select F3 to access long-term data.
Step 4: Review the most recent date of service at the top i.e., 03/01/02-999999.
Step 5: If the member is in a facility, there will be a letter under level of care (LOC) and a provider number.
Step 6: If there is not provider number and a letter under WAV TYP, then the member is on a waiver and eligible for medical equipment approval.
Step 7: If there is a letter R under LOC and a number under PROV NUMBER, the medical equipment can be reviewed. The letter R is for Residential Care Facility (RCF) and is the same level of care as living at home.
Step 8: If the member has primary insurance coverage (02 or 06), enter the primary insurance redaction in Box 25. If the member is assigned to an HMO that covers DME, non-adjudicate the PA with the HMO redaction in Box 25. The RA will return the PA to the provider.
Step 9: The RC will also review MMIS File 5 for other items owned by the member to prevent duplication.
Step10: The RA and/or RC will determine medical necessity by reviewing Boxes 15, 16, 17 and 19 on the PA Request Form and the attached documentation.

a. For most items (standers, manual and power wheelchairs, gait trainers, posture control walkers, etc.) a physical therapy report is required.
b. A manufacturer's suggested retail price or provider cost for all requested items must accompany the PA request.
c. A certificate of medical necessity or documentation to support medical necessity must be signed and dated by the physician. Each item on the request must be supported as medically necessary and cost effective.

Step 11: The RA and/or RC will verify and change codes if appropriate for items requested.
Step 12: The RA and/or RC will review policy for requested items in the DME section of Provider manual.

a. The Provider manual may be accessed via Internet explorer by double clicking on the following link: http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/PolManual.htm.

Step 13: The RC will cross reference using PDAC https://www.dmepdac.com/dmecsapp/do/search and Healthcare Common Procedure Coding System (HCPCS) for coding purposes.

Step 14: The RC will cross reference using Centers for Medicare and Medicaid (CMS), https://www.noridianmedicare.com/ for guidelines on items requested. If there are no appropriate HCPCS codes, a miscellaneous code will be used and priced at MSRP minus 15 percent or provider cost plus 10 percent.
Step 15: Although a PA may not be required for some medical equipment, requests from providers will be processed if the item suspends for medical review.
Step 16: The RC will review the Iowa Administrative Code (IAC) as needed via Internet explorer. The IAC URL address is: http://www.dhs.state.ia.us/policyanalysis/RulesPages/RulesChap.htm.
Step 17: If additional information is needed for a PA, the RC will complete a request for additional information template in workflow.
a. Only information that is necessary to approve the service will be requested.
Step 18: For all items that are determined to be medically necessary, the DME PAs are approved for a six-month date span to allow adequate time for equipment to be fitted and ordered.
Step 19: If the RC questions medical necessity, the RC will refer the PA request to the MMD or CR for determination.
a. The MMD or CR will review all denials and modifications for review.
Step 20: The RC will enter the authorization in MMIS.
a. For denied authorizations, the RC will generate a denial letter to the member by putting Y for Rcp-letter in file.
Step 21: The RC will enter the reason code for denial.
Step 22: The RC will enter comments in free-form text area in F5 in MMIS for clarification.
Step 23: The MMIS system will generate a notice of decision (NOD) to the member with attached appeal rights on the back.
Step 24: Once the PA has been approved, modified or denied it will leave the RC's workflow and enter RA's approved to be sent or denied to be sent queues in OnBase.
Step 25: The RA will return the completed form to the provider. If the form was received by fax, it will be returned by fax. If it was received by mail, it will be returned by mail.

Forms/Reports:

Iowa Department of Human Services

AUGMENTATIVE COMMUNICATION SYSTEM SELECTION

Recipient Name	Medicaid Number	Date of Birth	
Address	City	State	Zip

Section A To be completed by physician. Use additional sheets as needed.

Medical diagnosis and history:

Medical prognosis:

Physician Signature	Name
Address	Phone

Section B To be completed by speech or language pathologist. Use additional sheets as needed.

Please describe current functional abilities in terms of:

Communications Skills:

Motor Status:

Sensory Status:

Cognitive Status:

470-2145 (9/88) -1-

Social/emotional status:

Language Status:

Information is also needed on the following:

Educational ability and needs:

Vocational potential:

Anticipated duration of need:

Prognosis regarding oral communication skills:

Prognosis with a particular device: (Has there been a trial period with this or a similar device?)

Recommendation: (Why this particular device? What other kinds of equipment have been used?)

Speech or Language Pathologist Signature	Name
Address	Phone

Section C To be completed by consultant or fiscal agent

Communication System ❑ Approved ❑ Denied Type Reason Signature

470-2145 (9/88) -2-

Interfaces:

Data Warehouse
MMIS
OnBase

RFP Reference:

6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:

N/A

MED - Prior Authorization Enteral Products and Supplies

Purpose: Most enteral products and supplies do not require a PA. Ninety-five percent of complete PA requests that do not require PR will be processed within ten business days of initial receipt.

Identification of Roles:

Review Coordinator (RC) – responds to PA requests, checks for overlap of service dates, screens requests for completeness and reviews for compliance with policy, medical necessity, appropriate units, and length of condition, additional consideration authorizations and forwards to PR when needed.

Review Assistant (RA) – logs PA request in OnBase, assigns PA to RC, sends requests for additional information, sends PAs to physician/consultant, returns PA to RC when information returns or back from physician/consultant, returns completed PA's to providers.

Medicaid Medical Director (MMD) – provides physician review and oversight and determines when a specialist consultant is necessary

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the request.

- Complete 95 percent of PA requests not requiring physician review enter into system and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.

For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

Path of Business Procedure:

Step 1: Upon receipt of the PA in review queue, the RC will complete eligibility determination.

a. If member has Medicare, complete using Medicare redaction note in Box 25. If the request is for an oral supplement and the member is not in a care facility (Medicare does not cover these supplements), Medicaid will be primary payor.
b. Check to see if member has Primary Insurance Coverage (02, 06, or 19) and utilize primary insurance redaction in Box 25, if applicable.
c. If the member is assigned to an HMO that covers DME, return the PA to the provider with the HMO redaction in Box 25.
d. If the request is for an oral supplement, check long term care data. If the member resides in a facility (except for RCF), oral supplements are not covered.

Step 2: The RC will review the dates of service and File 12 in MMIS to determine if there is an overlap of dates of service.

a. If there is a PA in place with another provider that overlaps with this request, select Create Letter task for Enteral Request for Additional Information requesting a discharge from the previous provider?
b. If there is a PA in place for the same time period with the same provider, the request may be a modification.
c. If a previous PA has been approved for pump rental (rate greater than 100cc/hr), and kits within the past year, the request can be recertified without PR review.
    1. If this is a request that is a yearly renewal and pump rate is greater than 100 cc/hr, PR must recertify pump and kits.

Considerations:

a. The PAs are generally granted in six month increments.
b. However they can be approved for longer periods, up to 12 months if the member is greater than four years of age and has a chronic lifetime condition.
c. Oral supplements should only be approved for 6 months, unless it will definitely be an ongoing need at the same calorie amount.
d. Members who are WIC eligible can only be certified for a 6-month period, even if the request is for supplies only.
e. Timely filing requires that the PA be submitted within 365 days of the start date of the PA.
f. If received after 365 days, the start date will be changed to start 365 days from the date the PA was received and units will be adjusted accordingly.
g. The PA cannot be requested more than three months prior to the initial date of service, i.e., start date is 12/1/08, and so PA cannot be approved prior to 9/1/08.

Step 3: For enteral products the RC will review the PA request for compliance with Medicaid policy:

a. The member has a metabolic or digestive disorder which prevents the member from obtaining the necessary nutritional value from usual foods in any form and which cannot be managed by avoidance of certain food products.
b. The member has severe pathology of the body that will not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition.
c. If the member resides in a nursing facility, oral supplements are not covered.
d. The member has severe pathology of the body which will not allow ingestion or absorption of sufficient nutrients from regular food, that is, 51 percent or more of the member's daily caloric need is supplied by an oral supplement.
e. Metabolic products for members with Phenylketonuria (PKU) disorder, even if administered orally, are approvable without meeting the 51 percent requirement
f. Amino acids are approvable for documented metabolic deficiencies

    Conditions that do not justify an approval are:

        a. Weight loss diets;
        b. Wired-shut jaws;
        c. Diabetic diets;

d. Milk or food allergies for recipients five years of age or older; or
e. Need to boost calories in the absence of severe pathology

Step 4: If all the required forms are not present, utilize Create Letter task selecting Enteral Request for Additional Information.
Step 5: If a PA comes in from the physician and no pharmacy is noted, return for additional information.

a. For vitamin supplements
    1. Physician order of dosage and frequency
    2. NDC
    3. Diagnosis
    4. Length of time member has been taking
    5. Justification for supplement
    6. Labs if applicable, to diagnosis
    7. Other treatments tried and failed, if applicable.

b. For amino acids
    - Physician order of dosage and frequency
    - NDC
    - Diagnosis
    - Justification for supplement
    - Other treatments tried and failed
c. Items being requested must be indicated on the CEN.

Completion of an authorization requires the following:

Step 1: Review of the submitted HCPCS codes for accuracy and change to correct code if needed in Box 16.

Step 2: Enter the approved units of service in Box 18. Approved units are based on medical need.

Step 3: Modifiers, if applicable, must also be entered on the PA form:

a. RR = rental
b. BO = oral supplement
c. BA= pump kits to reimburse at gravity kit fee schedule if pump rate is over 100cc/hr

a. Additional deductions may be applicable as directed by DHS.

Step 4: The RC determines the appropriate units to be approved in Box 18 and the amount to be authorized in Box 20. The following procedure is used when calculating units and pricing for Enteral nutrition.

a. One unit = 100 calories. The formula for calculating units needed is as follows: Number of calories per day/100 = Number of units per day x number of days = number of units needed.
b. Enter this amount in Box 18.
c. Check NDC number with pricing list for unit price of enteral nutrition requested.
d. Locate NDC on MediSpan data list by accessing http://dhsmoss1/ime/bltc/Reports/Forms/AllItems.aspx
e. If NDC number is not on pricing list, look it up on Medispan. Enter the product information into the enteral pricing list. (Subtract 10 percent from the price. Divide this number by the number of calorie units there are in one can/packet/bottle of that product. This is the price/unit that is to be entered in Box 20. The priced is automatically calculated once entered into the pricing list)
f. If member receives WIC, units supplied by WIC are to be subtracted from total units needed.
    1. The remaining units may be approved. The formula for calculating the number of units supplied by WIC is as follows: number of calories per can/100 x number of cans supplied by WIC x number of months eligible for WIC equals number of units provided by WIC. Total number of units needed minus number of units provided by WIC equals number of units needed form Medicaid..
    2. The manufacturer's websites can be used to research nutritional supplies to assist in determining units and price. Current manufacturers include

but are not limited to Novartis, Abbott, Nutrition, Nestle, and Mead Johnson.

Step 5: For requests of an Enteral pump, the RC will review previous PA pump approvals in MMIS, review for medical necessity, including a statement identifying the medical reason for not using a gravity feeding set.
Step 6: For enteral pumps, the RC will review the PA request for compliance with Medicaid policy and identification of at least one of the following:

a. Gravity not satisfactory due to reflux and/or aspiration
b. Severe diarrhea
c. Dumping syndrome
d. Administration rate is equal to or less than 100 ml/hour

e. Blood glucose fluctuations
f. Circulatory overload
g. Jejunostomy tube used for feeding
h. Oil based formula
i. Length and time of the feeding
j. Surgical conditions which affect the feedings
k. Rental only
l. Feedings given by more than one method e.g. pump and bolus

Step 7: If the PA is received for pump kits only pump criteria must be met**Step 8:** If a PA is received for supplies only (pump rental and supplies) the following should be included on the CMN

a. Pump rate and medical necessity for pump instead of gravity.
b. Documentation of the type of device being used (gastrostomy etc.).
c. Date supplies were ordered
d. Physician's signature and date of signing

a.

Forms/Reports:

The link to the Certification of Enteral Nutrition form is:
http://dhs.iowa.gov/ime/providers/forms

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:
N/A

MED - Prior Authorization Physician Procedures

Purpose: If a provider is unsure that Medicaid will cover a surgical procedure, the provider may submit a request for prior approval. Physician administered drugs are also reviewed. Some require PA. Others are reviewed at physician request due to their high cost.

Identification of Roles:
Review Assistant (RA) – logs PA request in OnBase, Assigns PA to RC, Sends requests for additional information, sends PA's to physician/consultant, returns PA to RC when information returns or back from physician/consultant, returns completed PA's to providers.

Review Coordinator (RC) – responds to PA requests, checks for duplicate items, screens requests for completeness and reviews for compliance with policy, medical necessity, and forwards to physician for review when needed.

Medicaid Medical Director (MMD) – provides physician review and oversight and determines when a specialist consultant is necessary

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the request.

- Complete 95 percent of prior authorization (PA) requests not requiring physician review enter into system and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to

allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

Path of Business Procedure:

Step 1: The RA and/or RC will log a physician procedure PA and assign to RC from the Med 11- Logging queue in Workflow.
Step 2: The RC will review member eligibility in MMIS.
Step 3: If member is Medicare eligible, check procedure being requesting in MMIS File 06 to see if Medicare pays for that procedure. If procedure is covered under Medicare, continue the review and put the following redaction in Box 25 of the PA:

a. Records indicate this member has Medicare.
    i. Be advised that obtaining a PA only establishes medical necessity under the Medicaid guidelines.
    ii. The PA does not override Medicare coverage

Step 4: If member has an HMO, the HMO should cover the procedure.

a. Put a redaction note in Box 25 of the PA stating, Records indicate that this member is covered by a HMO. This request for PA must be submitted to the member's HMO provider. Contact the ELVS line at 1-800-338-7752 to identify the provider.
b. Make a strike through redaction through Boxes 18, 20 and 21 on PA. This will let the provider know that the PA was reviewed.
c. Make an undo redaction through the PA number on the PA form to remove the number prior to returning form to the provider.
d. Leave the PA number in the keywords yellow Box in OnBase.
e. This is not a denial; it is returning the PA to the provider telling them that they have submitted the PA to the wrong authorization department.
f. In OnBase, click on the denial icon
g. Click non-adjudicated on the left side of the screen.

Step 5: If member has primary insurance noted in the TPL category in MMIS File 10 and coverage type 06, the requested surgical procedure may be covered by other insurance. Make a redaction note in Box 25 on PA form stating, member has a TPL and an EOB must be submitted with claims.
Step 6: Continue to process PA as normal.
Step 7: The RC will screen the request for completeness including:

a. Office notes
b. Consultant's notes
c. Failed Treatments
d. Pictures if Applicable

Step 8: If more information is needed prior to review, the RC will select Create Letter task and complete appropriate template.
Step 9: The RC will pend the request by selecting pend to provider.
Step 10: The RA and/or RC will return the request for additional information to the provider.
Step 11: The RC will print hard copy for reviews that have pictures and/or that are more than 15 pages long, if unable to complete the review on line.

Step 12: The RC will obtain physician review (PR) by completing the MD router in OnBase to send to reviewer, noting specific criteria of the request and if pictures accompany request.

a.

Step 13: The RC will review the IAC as needed via Internet explorer. The Administrative Rules' URL address is
http://www.dhs.state.ia.us/policyanalysis/RulesPages/RulesChap.htm

Forms/Reports:

N/A

Interfaces:

Data Warehouse
MMIS
OnBase

RFP Reference:
6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:
N/A

MED - Prior Authorization Audiology

Purpose: A PA is required when replacing a hearing aid that is less than 4 years old for an adult. A PA is also required for any aid that exceeds $650.00 for monaural or $1,300.00 for binaural. Payment can be made when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing which would require a different hearing aid.

Identification of Roles:
Review Assistant (RA) – logs PA request in OnBase, Assigns PA to RC, Sends out Requests for additional information, sends PAs to physician/consultant, returns PA to RC when information returns or back from physician/consultant, returns completed PAs to providers.

Review Coordinator (RC) – responds to PA requests, checks for duplicate items, screens requests for completeness and reviews for compliance with policy, medical necessity, appropriate units and forwards to physician for review when needed.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Physician Reviewer (PR) – external physician reviewing medical records for a variety of reasons.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Consultant Reviewer (CR) – provides determination for authorizations regarding questioned medical necessity.

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the request.

- Complete 95 percent of prior authorization (PA) requests not requiring physician review enter into system and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

Path of Business Procedure:

Step 1: The RC will review member eligibility in MMIS File 10:

a. If member has primary insurance coverage (06) place insurance redaction in Box 25 of PA.

Step 2: The RC will note past services on consultant review form, including HCPCS code billed, date of service, and left or right aid (V5050, rt, 2/20/05)

a. If no code is listed, write No previous Hearing Aids through Medicaid, on the template.

Step 3: The RC will review the PA for the requested codes.

Step 4: The RC will review for complete information submitted with request An invoice for the requested hearing aids or a signed PA with the cost of the hearing aids is required.

a. Member history and diagnosis
b. Date of purchase of initial hearing aid or date of first binaural hearing aids
c. Reason for replacement, include if exact same type and model are being requested as was previously provided
d. Form 470-4767 fully completed and signedMember over 18 years of age can sign waiver to not have a physical examination. On form 470-4767, either the signed waiver or the Physician's Rx must be checked "yes".
e. For monaural hearing aids costing more than $650.00 and for binaural aids costing more than $1300.00, documentation must indicate educational or vocational necessity.
f. Current audiology testing
g. For initial purchase only of binaural hearing aids, medical necessity in accordance to the Iowa Administrative Code must be submitted

Step 5: All audiology PAs go to a consultant for review except requests for batteries and replacement of the exact same aids that were lost or broken.

Step 6: The RC will complete peer review form in OnBase and pend for consultant review.

Step 7: The RA and/or RC will send review to peer reviewer.

a.

Step 8: The RC will enter Invoice in Box 20 of PA.

a. If invoice for hearing aid does not accompany the PA or there is no amount listed on the PA, make a note in box 25 of the PA that payment is made per invoice and the invoice needs to be submitted with the claim.

Step 9: If additional information is needed, the RC will complete a request for information.
Step 10: When the necessary information is returned, the RA will forward the request and supporting documentation to the appropriate RC for review.
Step 11: The RC will review to see if all documentation requested has been returned.
Step 12: If all of the information is present for review, the RC will write on the peer review form the type and last dispensing date for hearing aids.
Step 13: The RC will forward the PA to the RA to send for consultant review.
Step 14: Upon return of the consultant's recommendation, the RC will complete the PA based on the decision.

Forms/Reports:

The Examiner Report of Need for a Hearing Aid form #470-4767 can be found using the following link:http://dhs.iowa.gov/ime/providers/forms

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:
N/A

MED - Prior Authorization Dental Services

Purpose: A PA is required for endodontic re-treatment, periodontal services, partial dentures, fixed partial dentures, crowns, orthodontic services, replacement dentures and partial dentures, rebases, implant services, and occlusal guards.

Identification of Roles:
Review Assistant (RA) – logs PA request in OnBase, Assigns PA to RA, sends requests for additional information, sends PAs to Internal Review Coordinator after checking eligibility, TPL and claims history, completes PA when information returns from IRC or comes back from physician/consultant, returns completed PAs to providers, answers phone calls from providers and refers calls to IRC as needed.

Internal Review Coordinator (IRC) – responds to PA requests, reviews for compliance with Medicaid policy, dental necessity, appropriate units, and length of treatment, coordinates to peer reviewer activity, checks eligibility, TPL and claims history, ,

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Consultant Reviewer (CR) – provides peer review determination for authorizations regarding questioned medical necessity.

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the request.

- Complete 95 percent of PA requests not requiring physician review enter into system and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

Path of Business Procedure:

Step 1: The RA will log a Dental PA and assign to the appropriate RA and/or IRC from the Med 11- Logging queue in Workflow.
Step 2: The RA and/or IRC will complete eligibility determination
Step 3: RA and/or IRC will note TPL coverage type 15 and redact TPL note on PA if applicable
Step 4: The RA and/or IRC will review MMIS File 5 for previous claims if applicable.
Step 5: The RA and/or IRC will send to IRC queue
Step 6: The IRC will review for dental necessity by reviewing boxes 13, 15, 16, and 17 on the PA request form and attached documentation

a. If additional documentation is needed IRC will generate letter of additional information and will forward this request back to RA's review queue to be sent
b. If consultant review is needed, IRC will generate CR sheet and send all necessary documents to consultant

Step 7: After receiving the decision from the CR, the RA will scan the CR sheets and attach the CR sheet to PA from logging in OnBase
Step 8: The RA and/or IRC will enter PA in OnBase and MMIS
Step 9: The RA will print the completed PA form and match with the additional documentation such as x-rays and photos
Step 10: The RA will then mail the completed review back to the provider

Forms/Reports:

N/A

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:
N/A

MED- Prior Authorization Vision

Purpose: A PA is required for a second lens correction within a 24-month period for members eight years of age and older; subnormal visual aids where near visual acuity is greater than 20/100 at 16 inches, 2M print; visual therapy when warranted by case history or diagnosis (convergence insufficiency and amblyopias) for a period not greater than 90 days. Visual therapy is not covered when provided by opticians.

Identification of Roles:
Review Assistant (RA) – logs PA request in OnBase, Assigns PA to RC, sends out requests for additional information, sends PAs to physician/consultant, returns PA to RC when information returns or back from physician/consultant, returns completed PAs to providers.

Review Coordinator (RC) – responds to PA requests, checks for duplicate items, screens requests for completeness and reviews for compliance with policy, medical necessity and appropriate units and forwards to physician for review when needed.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Consultant Reviewer (CR) – provides determination for authorizations regarding questioned medical necessity.

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the reque

- Complete 95 percent of PA requests not requiring physician review enter into system and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

Path of Business Procedure:

Step 1: The RA and/or RC will log a vision PA and assign to the appropriate RC from the Med 11- Logging queue in Workflow.

Step 2: The RC will select a vision PA from Med11 Review queue.

Step 3: The RC will complete eligibility determination.

a. Check to see if member has Primary Insurance Coverage (06 or 20 types cover vision), utilize primary insurance redaction in Box 25 if applicable and continue to process authorization request.
    1. If the member is assigned to an HMO, return the PA to the provider with the HMO redaction in Box 25. Make an undo redaction over the PA number in Box 12 to remove the PA number.

a. If the member has Medicare, Medicare will cover the first pair of glasses following cataract surgery.

Step 4: The RC will review MMIS File 10 for service limitations:

a. Note of date of last eye exam, lenses, and frames and the codes billed for these services.
b. Date of last exam or lenses should be within 30 days of the previous prescription
c. If recipient not on limit file appears, the member does not have any limits. If the member is on file, check the age of member, the dates and services provided to verify if the PA falls within the limits.

Step 5: If member limits do not prohibit the approval, proceed to verify the following information that is needed for each request:

a. New Lenses: Previous and present diopter readings with date.
b. Replacement of frames or lenses: Reason why replacement is needed and prescription for new lenses.
c. Contacts: Present diopter readings, diagnosis if applicable, visual acuity with glasses, and visual acuity with contacts.
d. Visual Therapy: Length of treatment, documentation of medical necessity
e. Visual Aids: Present diopter readings, documentation of medical necessity
f. Eye exam: Documentation of complaint or symptom of an eye disease or injury.

Step 6: The RC may approve the following services without consultant review:

a. Routine eye exams (once in 12 months).
b. New or replacement lenses and/or frames if no limitation noted for client.
c. Change in lenses where there is a 0.5 change in either sphere, cylinder, or a 10 degree change in axis of either eye.
    1. If the change requirement is met, in one lens, the other lens is approved.

Step 7: When consultant review is necessary the RC will forward the PA to the RA to send to the CR.
Step 4: Upon return of the CR's recommendation, the RC will complete the PA based on CR's decision.

Forms/Reports:
N/A

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:
N/A

MED - Prior Authorization High Tech Radiology Approval Process

Purpose: A PA is required for high tech radiology requests with certain procedure codes. The McKesson Clear Coverage web-based portal is used to gather the information for these reviews. Ninety-five percent of complete PA requests that do not require peer review will be processed within ten business days of initial receipt

Identification of Roles:
Project Assistant (PA) or Review Assistant (RA) – Assists in processing peer review information and with logging and assigning information in OnBase.

Review Coordinator (RC) – responds to PA requests, checks for duplicate items, screens requests for completeness and reviews for compliance with policy, medical necessity and appropriate units and forwards to physician for review when needed.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Physician Reviewer (PR) – external physician reviewing medical records for a variety of reasons.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the request.

- Complete 95 percent of PA requests not requiring physician review enter into system and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

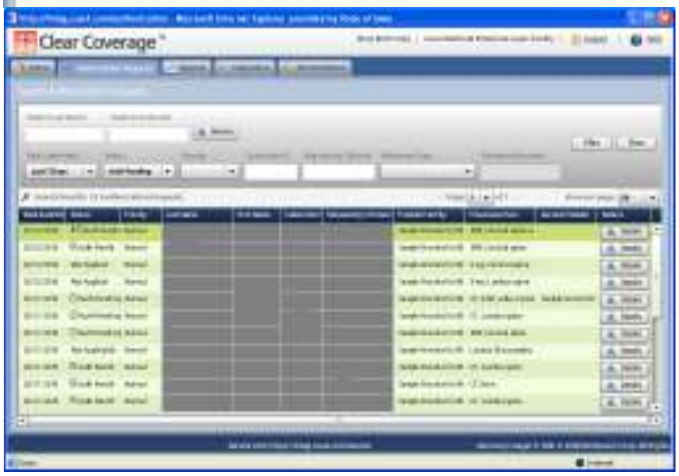
Path of Business Procedure:

Step 1: The RC will access the Clear Coverage web portal here:https://prod.cue4.com/authorization

Step 2: Log onto Clear Coverage website at http://prod.cue4.com/authorization

Step 3: Enter user name and password provided to you.

Step 4: Click tab for Authorization Search at top of the page.

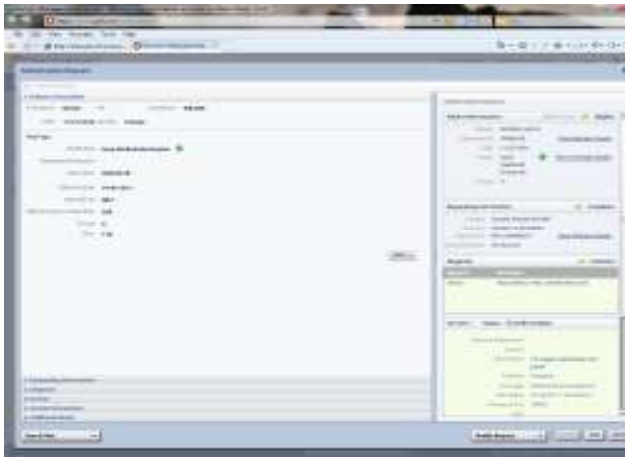


Step 5: The RC will address URGENT/EMERGENT requests first by scrolling through the authorizations or clicking on the “Priority” header.

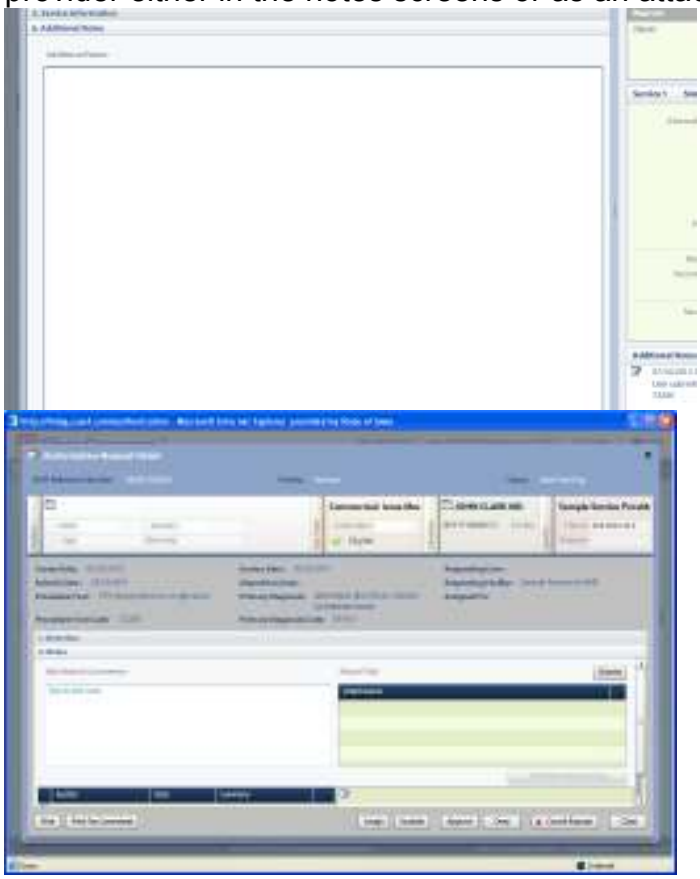
Step 6: After finishing these requests, the RC will work on OLDEST pended authorizations first.

Step 7: Click on DETAIL button on right to select authorization.

a. This will bring up the Authorization Request screen.
b. If need to request additional clinical information call or e-mail provider
c. Enter note of the action taken in the PA file under the notes section



Step 8: Click Additional Notes accordion to view additional clinical information entered by provider either in the notes screens or as an attachment to the request.



Step 9: This will mark this authorization with a red arrow to show it has been escalated to peer review.

a. E-mail consultant with the ADM number of PA, test ordered and date request submitted for all request requiring review

Step 10: In the e-mail refer to the ADM number as the Request number

Step 11: In OnBase go to file, forms, choose MED Radiology Peer Review E-Form. This will create a Radiology peer review sheet.

Step 12: Enter name of test and the RC's number under Additional Concerns/Comments.

Step 13: Attach radiology peer review sheet with e-mail to consultant.

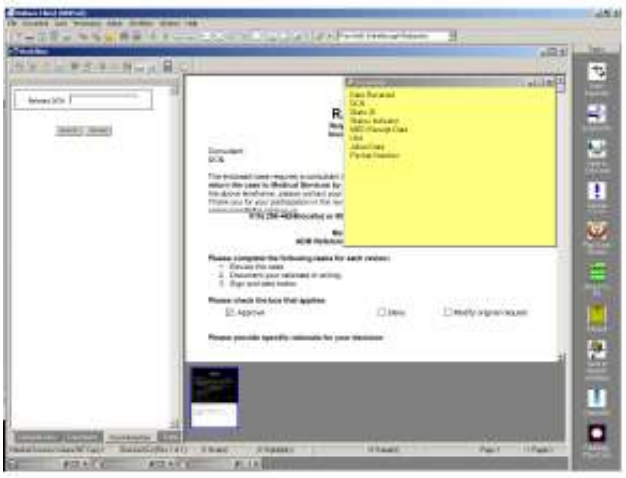
Step 14: Processes for PR approved authorizations:

Step 15: When the peer review sheet comes back into the PA services e-mail box the RA will open the peer review sheet and verify that it is approved or denied.

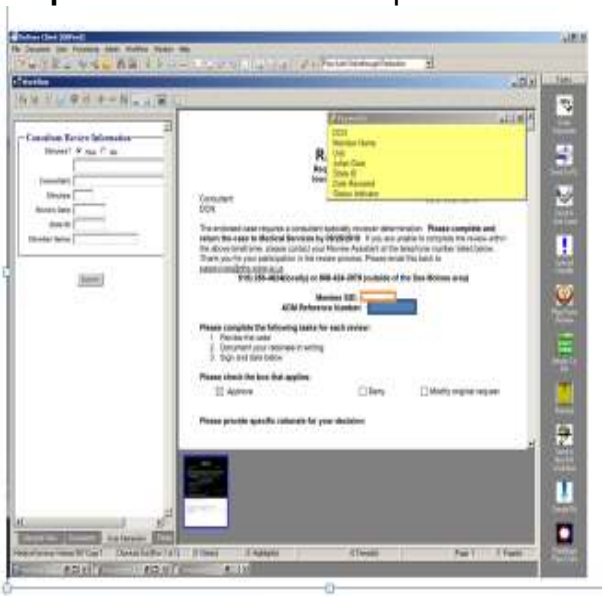
Step 16: If the peer review sheet is approved the RA will import the peer review sheet into the MED11 pa logging queue.

Step 17: In logging there is a task Radiology Phys/Cons. Run the task and if the pa has been approved in Clear Coverage you will be requested to enter the DCN number off the Peer Review Sheet.

Step 18: Click submit.



Step 19: Data enter the requested information off the Peer Review Sheet.



a. The document will vanish from the logging queue.

Forms/Reports:
N/A

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:
N/A

MED - Prior Authorization High Tech Radiology Denied Authorizations Process

Purpose: A PA is required for high tech radiology requests with certain procedure codes. The McKesson Clear Coverage web-based portal is used to gather the information for these reviews. Ninety-five percent of complete PA requests that do not require peer review will be processed within ten business days of initial receipt.

Identification of Roles:
Project Assistant (PA) or Review Assistant (RA) – Assists in processing peer review information and with logging and assigning information in OnBase.

Review Coordinator (RC) – responds to PA requests, checks for duplicate items, screens requests for completeness and reviews for compliance with policy, medical necessity and appropriate units and forwards to physician for review when needed.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Physician Reviewer (PR) – external physician reviewing medical records for a variety of reasons.

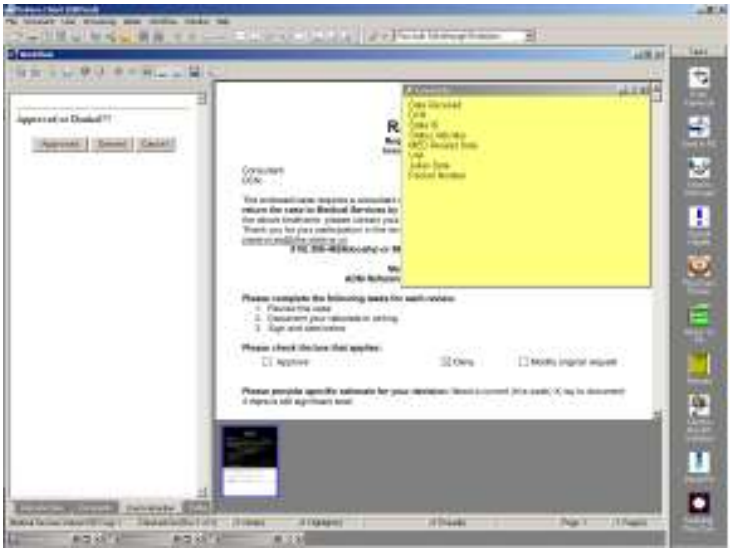
Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the request.

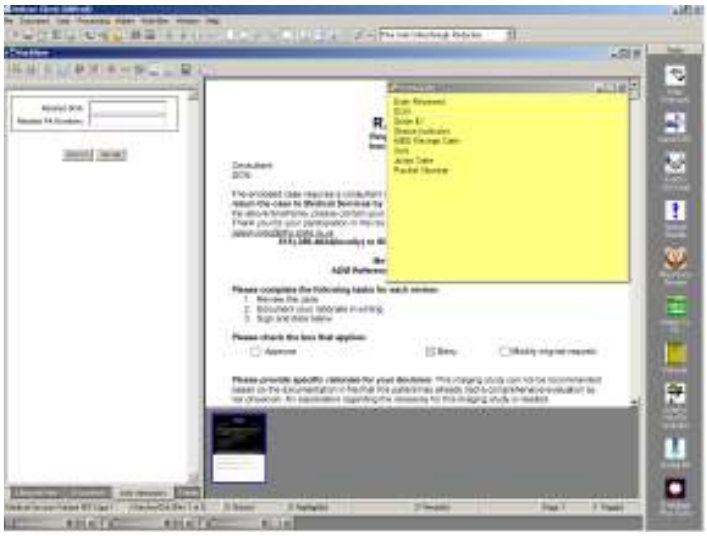
- Complete 95 percent of PA requests not requiring physician review enter into system and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

Path of Business Procedure:

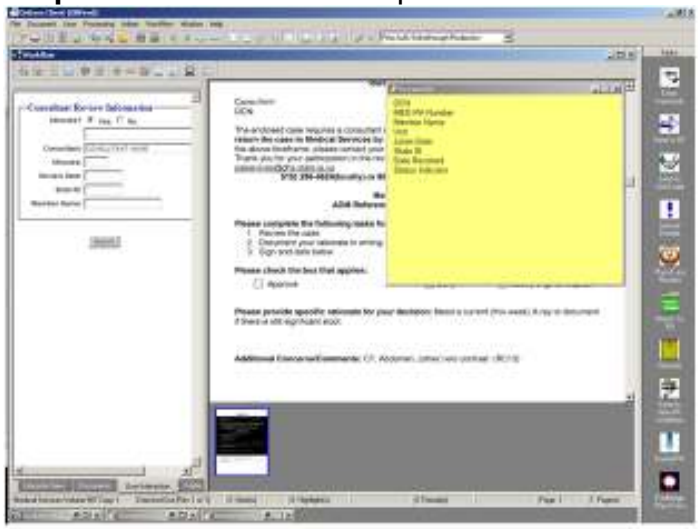
Step 1: When the peer review sheet comes back into the PA services e-mail box the RA will open the peer review sheet and verify that it is a denied PA.
Step 2: The RA will email the denied peer review sheet to the RC that requested the peer review.
Step 3: The RC will ensure that the PR rationale and the IAC reason for denial is in Clear Coverage.
Step 4: The RA will import the denied PA PDF file from Clear Coverage into MED11 logging queue.
Step 5: The RA will import the denied peer review sheet into MED11 logging.
Step 6: Logging the PA PDF as a radiology PA.
Step 7: The RA will run the Radiology Phys/Cons task in on-base.
Step 8: Once the peer review sheet is in the MED11 logging the RA will run the Radiology Phys/Cons task.



Step 9: The RA will click on denied.
Step 10: The RA will type the DCN and the prior authorization number of the PA. Click on submit.



Step 11: Data enter the requested information off the Peer Review Sheet.



Step 12: The RA will click submit.
Step 13: The RA will send the denial to the RA's review queue that originally sent the request to the consultant.
Step 14: When a radiology denial comes through to the RA's review queue, the RA will enter the PR's rationale and IAC into MMIS. The denial code is (065) which is 441-79.9(2) Member need was not supported by documentation submitted.
Step 15: The RA will complete the OnBase process by clicking the denied button.
Step 16: The copies of the first two pages of Clear Coverage PDF will be sent with member's denial letter.

Forms/Reports:

N/A

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:
N/A

MED - Prior Authorization Request for Additional Information

Purpose: The PA requests with missing information will be processed upon return of the completed request. For PA requests requiring additional medical necessity documentation, 100 percent will be processed within 60 days of initial receipt but not denied prior to 45 business days from initial receipt if additional information is not received. Only information necessary to approve the service will be requested.

Identification of Roles:
Review Coordinator (RC) – reviews PA requests and requests additional information.

Review Assistant (RA) – mails and/or faxes PA request form and follow up with providers as needed.

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the request.

- Complete 95 percent of PA requests not requiring physician review enter into system and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

Path of Business Procedure:
Step 1: The RA and/or RC will review submitted documentation to insure that the request is complete.

Step 2: The RA and/or RC will complete a request for additional information, if needed. Only information that is necessary to approve the service will be requested.
Step 3: The RAs do not make clinical decisions or complete clinical interpretation of information.
Step 4: Upon determination that a PA request contains incorrect information, is missing information, or requires additional documentation, the RC will double click on Create Letter task in OnBase and select the appropriate letter template.
Step 5: The letter will be auto-populated with the date and with provider and member information. The RC will complete a Request for Information form i.e. MED Info Req-Enteral in OnBase.
Step 6: With the document in review open in Workflow, the RC will tab through the document, press enter on the Box at each applicable item.
Step 7: If documentation not identified by an item is needed, the RC will check Box at other and tab to text space to enter clarifying information regarding the request.

a. The RC will close out of the template
b. The RC will click on Save Changes.
c. This will attach the information request to the PA.
d. The RC will choose pend in the tasks bar.
    1. A question will appear
        a. Do you need to send this back to the provider for more information or is it going to Physician/Consultant review?
        b. Choose Provider.

Step 8: The RA will return the PA additional information form request to the provider.
Step 9: The RA will find the document in the To Be Pended queue and choose Send to Pending from the tasks bar.
Step 10: The RA will then choose if going to fax or mail the additional information request. The document will go to Fax Pending queue if faxed or Pending queue if mailed.
Step 11: Upon receipt of the corrected request and/or supporting documentation, the RA will distribute to the appropriate RC.
Step 12: The RA will find the returned document Logging queue.
Step 13: The RA will click on attach to PA from the tasks bar.
Step 14: The RC will find the PA with the returned information in the Review queue.
Step 15: After 15 days, the PA will move to follow up with provider queue.
Step 16: The RA will select create letter task and complete information in the reminder letter.
Step 17: The RA will send a second reminder at 30 days.
Step 18: If additional information is not received within 45 days, the RC will complete a technical denial.

Forms/Reports:

N/A

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:
N/A

Med - Prior Authorization Physician and/or Consultant Review

Purpose: To obtain a physician or consultant review for medical necessity or to be in compliance with Medicaid and URAC Guidelines.

Only peer reviewers make denial decisions. Peer reviewers include licensed health care professionals in the same category as the attending provider. Denials made by the CAMD will be reviewed by the physician MMD. Notice of the availability of the peer-to-peer conversation is included on the IME website http://dhs.iowa.gov/ime/providers/rights-and-responsibilities

The manager will arrange for the peer-to-peer conversation within one business day of the request unless there are extenuating circumstances.

Identification of Roles:
Review Coordinator (RC) Internal Review Coordinator (IRC) – requests physician or consultant review for medical necessity prior to completing the PA.

Review Assistant (RA) – forward request to physician review and follow up as needed.

Medicaid Medical Director (MMD) – completes physician review or determines that a specialist consultant is necessary.

Consultant Reviewer (CR) - completes review in accordance with medical criteria.

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the request.

- Complete 95 percent of PA requests not requiring physician review enter into system and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not receipt (to allow time for receipt of the requested information) and no later than 60 days of initial
  receipt. Complete 100 percent within 60 business days of initial receipt.

Path of Business Procedure:

Step 1: Upon determination that a PA request requires a PR the RC will complete a PR or CR form from a template in OnBase and attach it to the PA request.
Step 2: The RA, RC, and/or IRC will click on Create Letter task and choose MED MD Router template for physician review or MED PA Peer Review template for consultant review, and then fill in the appropriate information on the request.
Step 3: The RA, RC and/or IRC will close the template and select save changes.
Step 4: This will attach the physician/consultant review request to the PA request.
Step 5: The RA, RC and/or IRC will then choose pend in the tasks bar.
Step 6: A question will appear:

a. Do you need to send this back to the provider for more information or is it going to Physician/Consultant review?

Step 7: Choose Physician/Consultant select either Physician or Peer Reviewer.
Step 8: The document will go to the Consultant Pending queue.
Step 9: The RA will forward by email or fax the PA request to the appropriate consultant dentist, orthodontist, audiologist, optometrist, speech pathologist or psychologist for review.
Step 10: The RA will receive any additions or changes to the peer reviewer list from manager.
Step 11: When the PR comes back from the consultant, the RA will log the number of minutes spent by the PR on the review on keywords tasks.
Step 12: The MMD may elect to have any request forwarded to a specialist or a consultant such as a pediatrician or surgeon.
Step 13: If consultant is outside of office, the RA will either email or fax the PA request to the consultant.
Step 14: If a PA request has not returned from the PR and/or CR within four days, the document will go to the follow-up with consultant queue.
Step 15: The RA will contact the physician and/or consultant regarding the status of the PA.

Step 16: When the document is returned, the RA will scan it or virtual print into the PA workflow in OnBase and/or attach to the PA by clicking on PR and/or CR Complete from the tasks bar.
Step 17: The RA, RC and/or IRC will then find the document in the back from consultant queue.
Step 18: The RC will click on approve or deny from the tasks bar.
Step 19: The RA, RC and/or IRC will enter the authorization in MMIS and complete OnBase approval, modification or denial.

Forms/Reports:

Medical Services Prior Authorization - Request for Peer Review
Iowa Medicaid Enterprise

Consultant: Date:

The enclosed case requires a consultant specialty reviewer determination. **Please complete and return the case to Medical Services by** . You may fax your response to 515-725-1356. If you are unable to complete the review within the above timeframe, please contact your Review Assistant at the telephone number listed below. Thank you for your participation in the review process.

515) 256-4624 (locally) or 888-424-2070 (outside of the Des Moines area)

Prior Authorization #:

Member Name: Member SID:

Please complete the following tasks for each review:

1. Review the case
2. Document your rationale in writing
3. Sign and date below

Please check the box that applies:

☐ Approve ☐ Deny ☐ Modify original request

Please provide specific rationale for your decision:

Additional Concerns/Comments:

Please indicate amount of time spent reviewing this case: minutes

Consultant Signature: _____ **Date**: _____

Medical Services – Request for Medical Director Review

DHS Policy Staff
☐ EPSDT
☐ Exception to Policy
☐ Lock-in
☐ Long Term Care
☐ Member Services
☐ Pharmacy Services
☐ Pre-Pay
☐ Prior Authorization
☐ Provider Services
☐ Retro Review
☐ SURS
☐ Targeted Case Mgmt
☐ Waiver

☐ Other (specify) _____☐

Person requesting review: _____ Ext: _____

Date: / /
Review Type: _____
Member Name: _____
Member ID: _____
Admission Date: _____
Discharge Date: _____

Date of Service: __/__/
Attending Physician: _____
Telephone #: _____
Hospital ID: _____
Hospital Name: _____
Hospital City: _____

Case Summary: (explain reason for Medical Director review - include known facts, concerns, etc.)

_____

Medical Director rationale for decision:

☐ Concern Identified ☐ No Concern Identified ☐ Approve ☐ Deny

☐ Immediate Action Recommended: _____

Additional concerns/comments: _____

indicate amount of time spent reviewing this case: _____

External consultants utilized: ☐ Yes (identify below) ☐ No

External consultant(s): _____

Medical Director Signature: _____ Date: _____

MDRouter/#05-

Interfaces:

Data Warehouse
MMIS
OnBase

RFP Reference:

6.2.5
6.2.5.1
6.2.5.2

6.2.5.3

Attachments:

N/A

Med - Prior Authorization Approval, Denial and Modification Decisions

Purpose: To process decisions made by the prior authorization department in a consistent manner.

Identification of Roles:

Review Assistant (RA) – Sends PAs to physician/consultant. Approves, modifies or denies some identified dental PAs. Redacts decisions on PA from in OnBase. Enters decision into MMIS. Returns completed PAs to Providers.

Review Coordinator (RC) – approves, modifies or denies PAs. Enters PAs into MMIS. Redacts decisions on PA form in OnBase. Enters decision into MMIS. Pends PAs that need Physician/Consultant Review. Returns completed PAs to Providers.

Internal Review Coordinator (IRC) – approves, modifies or denies dental PAs. Redacts decisions on PA form in OnBase. Enters decision into MMIS. Pends PAs which need Physician/Consultant review. Returns completed PAs to Providers

Physician Reviewer (PR) – Reviews PAs that need to be modified or denied.

Consultant Reviewer (CR) – Reviews PAs that need to be modified or denied

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the request.

- Complete 95 percent of PA requests not requiring physician review enter into system and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

Path of Business Procedure:

Step 1: Approval decisions are made in writing by faxed or mailed PA form and sent to the provider. Members and physicians may receive this statement upon request.
Step 2: Approval decisions may be reversed if additional information is received that contraindicates continued approval.

a. This would be done by attaching the new documentation received to the old PA in onbase and that will put the PA back into process for the change to be made to the old request.

Step 3: Denial and modification decisions are made in writing by MMIS and sent to the member. The written notice must include the principle reason and the clinical rationale for the decision.

a. Appeal rights are included in the notice.

Step 4: The RA, RC and/or IRC will return the completed form to the provider.
Step 5: If the form was received by fax, it will be returned by fax.
Step 6: If it was received by mail, it will be returned by mail.

Forms/Reports:

N/A

Interfaces:

Data Warehouse
MMIS
OnBase

RFP Reference:

6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:

N/A

Med - Prior Authorization MMIS Inquiry and Data Entry

Purpose: To enter or update PAs, inquire regarding status of PA request, to review previous PAs, inquire regarding member eligibility, and review claims.

Identification of Roles:

Review Assistant (RA) – Data entry of PA request in MMIS system.

Review Coordinator (RC) – Data entry of PA requests in MMIS system.

Internal Review Coordinator – Data entry of PA requests in MMIS system.

Path of Business Procedure:

The RA, RC or Internal Review Coordinator will:
Step 1: Click on the MMIS Sign on Screen

Step 2: Enter user ID and security code.
Step 3: On the Iowa MMIS Main Menu Screen, press enter.
- a. To complete inquiry regarding member eligibility, enter number 10 Recipient File and query under member's SID.
- b. To review claims, enter number 5 Claims File and query under member or provider ID.
- c. To complete entry and editing of authorizations and to complete inquiry regarding status of authorizations in MMIS, enter number 12 for PA file.
  1. For inquiry:
     a. Enter I for action code
     b. Enter PA number
     c. Press enter.

Step 4: If PA number is not known:
- a. Enter member SID or provider ID
- b. I for action code
- c. Press enter.
- d. To add or change PAs:
- e. Enter A or C for the action code
- f. Enter the PA number
- g. Authorization type
- h. Press enter

Step 5: After all data is entered as described in detail below, press enter.
- a. Errors will be highlighted for correction. Status will auto-populate to pended until authorization entry is complete and correct.
- b. Status can be changed to approved or denied at that time.
  - i. Approved and Pended status can be changed.
  - ii. Denied status cannot be changed.

Step 6: To review Claims history for PA's use file 5 for claims related to the PA requests:
- b. Put an (x) in front of All Claims Files
- c. Put members state ID under 2D.
- d. Put in range of codes (ex: K0001-K9999) in the procedure codes area
- e. Push Enter
  - i. This will bring up any past claims for the procedures for the member
- f. When claims appear, place the cursor on the first letter of the HCPCS code
  - i. Press F4
    1. This will give you a description of the code.
    2. Review for claims related to a wheelchair.

Step 7: Specific MMIS instructions for entering an authorization are as follows:
- a. MMIS is not case sensitive.
- b. Use the Page Up key to go back to a previous screen.
- c. The arrow keys can be used to move around when entering a PA.
- d. To correct a typo, use the delete or end keys, type over the error.

Step 8: Enter application number 12
- a. Press enter

Step 9: Enter action code A to add the PA
Step 10: Enter the PA number
Step 11: Enter the authorization type **Step 12:** Cursor goes to STATUS and enter A for approved or D for denied.
Step 13: If the PA is denied, tab to RCP-LTR and type Y.
- a. This will generate the recipient/member Notice of Decision (NOD) letter
- b. If the PA is approved, do not enter anything

Step 14: Tab to PROVIDER and type in the provider number.
- a. If legacy, seven digit, provider is not available and the only number available is the 10 digit NPI, RC may need to review the Provider File (09) to determine which legacy number is associated with the NPI
- b. MMIS will notify the user that this is needed at the end of entering data by displaying a message instructing the user to resolve errors

Step 15: Tab to MEDICAID-ID and type in the member ID number
- a. If the PA is denied, tab to REASON-CODE

Step 16: Enter the IAC denial reason code
- a. If the PA is not denied leave this blank

Step 17: Tab to PA-EFF-DATE
- a. Type in the start date of the PA

Step 18: Tab to PA-EXP-DATE and type in the end date of the PA
- a. Must use the MMDDYY format for all dates entered

Step 19: Tab to line 01. Under ST (status)
- a. Enter an A for approved or a D for denied

Step 20: Tab under FR-DTE
- a. Enter the start date for the item

Step 21: Tab under TO-DTE
- a. Enter the end date for the item
    1. These dates may be the same as the start and end dates for the PA or they may be different as long as they fall within the date range of the PA

Step 22: Tab under PROC-CODE
- a. Type in the HCPCS procedure code

Step 23: Tab under PROV-ID
- **a.** Type in the provider ID number (legacy or NPI)

Step 24: If the PA is denied, tab under RSN
- a. Enter the same denial reason code as used earlier

Step 25: Tab to line 02
- a. If there is more than one item on the PA
- b. Type in the information as did for line 01
    1. A maximum of three items can be entered per screen.

Step 26: Tab to line 01 of the REQUESTED area
- a. Each line here needs to correspond with the previous numbered lines.

Step 27: Tab under UNITS and type in the number of units requested by the provider.

Step 28: Tab under DOLLARS and type in the dollar amount requested.
- a. All dollar amounts must be entered in the 0.00 format

Step 29: Tab to UNITS under the APPROVED area

Step 30: Type in the number of units approved
- a. If the item is denied, type in 0

Step 31: Tab to DOLLARS under the APPROVED area and type in the dollar amount approved.
- a. If the item is paid per fee-schedule, do not enter anything.
- b. If the item is denied, type in 0.00 dollars

Step 32: Continue to enter information in the REQUESTED and APPROVED areas to correspond with the approved/denied procedure codes

Step 33: When done entering information on the first screen
- a. Press enter

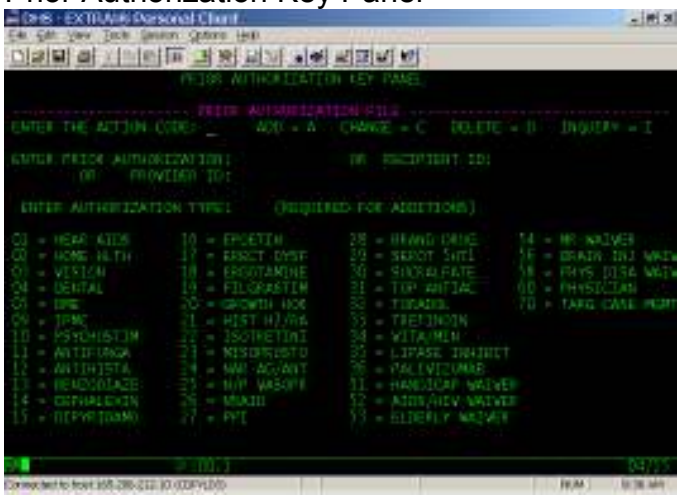
Step 34: If there are more than three items to enter, press F1 and a new screen will appear.
- a. Enter items as did for lines 01-03

Step 35: When all procedure codes and corresponding information have been entered, press enter and then F5.
- a. NOTES screen will appear

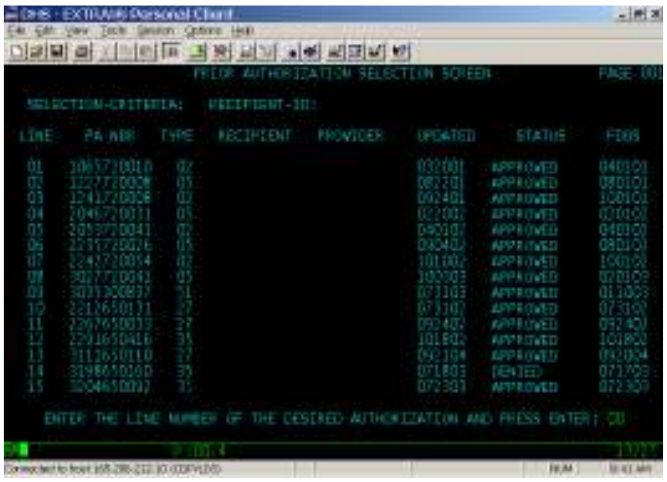
Step 36: Type in comments from Box 25 on the PA and any other needed information on this screen.

Step 37: Press enter.

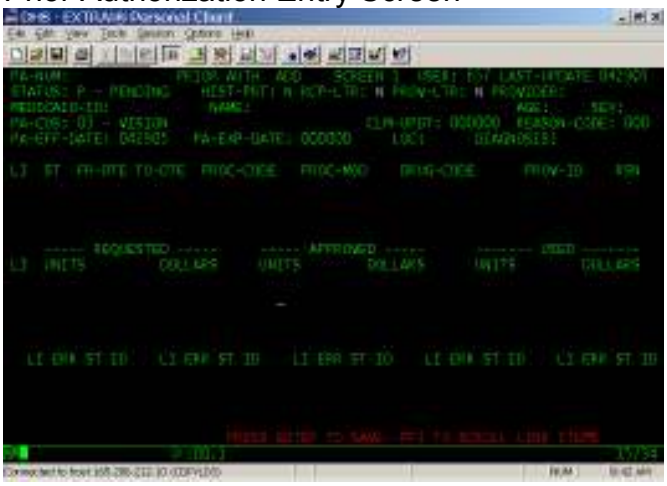
Prior Authorization Key Panel



Prior Authorization Selection Screen



Prior Authorization Entry Screen



Forms/Reports:

N/A

Interfaces:

Data Warehouse
MMIS
OnBase

RFP Reference:

6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:

N/A

MED - Prior Authorization OnBase Approval, Modification, and Denial

Purpose: To complete by approving, modifying or denying a PA on OnBase.

Identification of Roles:

Review Assistant (RA) – sends PA's to physician/consultant, returns completed PA's to Providers.

Review Coordinator (RC) – approves, modifies or denies PA's. Enters PA's into MMIS. Pends PA's that need Physician/Consultant Review.

Internal Review Coordinator – approves, modifies or denies PAs. Enters PAs into MMIS. Pends PAs that need Physician/Consultant Review.

Physician Reviewer (PR) – Reviews PA's that need to be modified or denied.

Consultant Reviewer (CR) – Reviews PA's that need to be modified or denied

Performance Standards:

In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the request.

- Complete 95 percent of PA requests not requiring physician review enter into system and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

Path of Business Procedure:

To complete a PA the RA, RC and/or Internal Review Coordinator will approve, modify, or deny a PA in OnBase workflow.

Step 1: If approval is necessary, the RA, RC and/or IRC will select the document that they are going to approve in the review, special handle, back from consultant, or care conference queue.

Step 2: The RA, RC and/or IRC will fill out the PA form using the redaction process.

Step 3: The RA, RC and/or IRC will double click the user task approve on the right side of the screen.

Step 4: System will ask, has eligibility been verified?

Step 5: The RA, RC and/or IRC will select yes or no.
a. If no, the RA, RC and/or IRC will check eligibility before continuing on.
Step 6: System will ask, Was this modified prior to approval?
Step 7: The RA, RC and/or IRC will select no.
Step 8: System will ask, Did you update MMIS?
Step 9: The RA, RC and/or IRC will select yes or no.
a. If no, RA, RC and/or IRC will enter the PA into MMIS before running this task.
Step 10: System will say, This document has been successfully approved.
Step 11: Document has been completed and will transition to Med 11- Approved (to be sent)
Step 12: The RA, RC and/or IRC will retrieve the document in Med11- Approved (to be sent) and double click Complete.
Step 13: The RA, RC and/or IRC will fax or mail.
a. If PA was faxed in, PA will be returned by fax
b. If PA was mailed in, PA will be returned by mail
Step 14: The document will transition to Med11- Approved Hold.
a. The document will remain in the queue for 15 days and then is removed from Workflow.

Modification:

Step 1: The RC will select the document that they are going to modify.
Step 2: The RC will select Create Letter task
Step 3: The RC will select Med modification Ltr-PA or Med Modification Ltr-EPSDT
Step 4: The RC will select OK.
a. Modification template will display on screen.
Step 5: The RC will enter the following:
a. Date of service
b. Requested service
c. Approved service
d. Reason for modification (IAC reference)
Step 6: The RC will close document and save changes.
Step 7: Modifications might have one of the lines denied or not have the same number of authorized units put in Box 18 as what was requested by the provider, which is in Box 17.
Step 8: The RC will fill out the PA form using the redaction process on page 68.
Step 9: For Denied lines:
a. The RC will put a line through Box 18 and Box 20.
b. The RC will write Denied in Box 21.
Step 10: For Approved lines:
a. Box 18, the RC will enter the approved amount of units.
b. Box 20, the RC will write FS if it's an item that is Fee Schedule, or the dollar amount for non-fee schedule items.
c. Box 21, the RC will write approved.

Step 11: Box 24, the RC will put an X in the Box by Approved even though the PA is modified.
Step 12: Box 25, the RC will put comments listing the reason why a modification was done.

Step 13: Box 26, the RC will put Medical Services and the date.
Step 14: The RC will double click the user task approve on the right side of the screen.
Step 15: System will ask, Has eligibility been verified?
Step 16: The RC will select yes or no.
a. If no, the RC will check eligibility before continuing on.
Step 17: System will ask, Was this modified prior to approval?
Step 18: The RC will select yes.
Step 19: System will ask, Did you update MMIS?
Step 20: The RC will select yes or no.
a. If no, the RC will enter the PA into MMIS before running this task.
Step 21: System will say, "This document has been successfully approved".
Step 22: Document has been completed and will transition to Med 11- Approved (to be sent)
Step 23: The RA will retrieve the document in Med11- Approved (to be sent) and double click Complete.
Step 24: The RA will select fax or mail.
a. If PA was faxed in, the PA will be returned by fax.
b. If PA was mailed in, the PA will be returned by mail.
Step 25: The document will transition to Med11- Approved Hold. The document will remain in the queue for 15 days and then is removed from Workflow.

Denial:
Step 1: All denied PAs will go to a PR and/or CR for review before being able to use the task Denied.
Step 2: Select the document to be denied from the Med11- back from Consultant queue.
Step 3: Fill out the PA form using the redaction process
Step 4: Denials will have all lines that are requested be denied
a. Box 18 and 20, the RC will put a line through the Box for each item that is requested.
b. Box 21, the RC will put Denied on each line that is requested.
c. Box 24, the RC will put an X in the Box by Denied.
d. Box 25, the RC will put comments listing the IAC.
e. Box 26, the RC will put Medical Services and the date.
Step 5: Double click the user task denied on the right side of the screen.
Step 6: System will ask, "Has eligibility been verified?"
Step 7: The RC will select yes or no. If no, RC will check eligibility before continuing on.
Step 8: System will ask, define the denial type:
Step 9: The RC will select Denial.
Step 10: System will ask, "Did you update MMIS?"
Step 11: The RC will select yes or no. If no, the RC will enter the PA into MMIS before running this task.
Step 12: System will ask, Has this Prior Auth been denied by a consultant?

Step 13: The RC will select yes or no.
a. If no, the RC will use the Pend task to send it to the physician or consultant before denying.

Step 14: System will say, “This has been successfully denied.”
Step 15: Document has been completed and will transition to Med 11- Approved (to be sent)
Step 16: The RA will retrieve the document in Med11- Approved (to be sent) and double click Complete.
Step 17: The RA will select fax or mail.

a. If PA was faxed in, the PA will be returned by fax.
b. If PA was mailed in, the PA will be returned by mail.

Forms/Reports:

Modification Letter

<Date>

Regarding Prior Authorization #:

<Member Name>
<Address>

Dear <Member Name>:

The Iowa Medicaid Program modified the Medicaid service(s) listed below for <Member Name>:

Provider Name:
Date of Service:
Requested Service(s):
Approved Service(s):

Reason for Modification: (IAC reference)

You have the right to appeal. See the back of this letter to find out how to file an appeal.

Sincerely,

Iowa Medicaid Enterprise
Medical Services

470-4174 (Rev 8/07)

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:
N/A

MED - Prior Authorization Appeal Process

Purpose: A Medicaid member who disagrees with a Medicaid decision regarding Medicaid services has the right to appeal within 30 days of the date of the notice of decision letter by contacting the local DHS office, by writing a letter to DHS Appeals Section or by filing on line at http://www.dhs.state.ia.us/dhs/appeals/appeal_decision.html. The notice of decision letter contains instruction on how to request an appeal. Medical Services provides testimony for assigned appeal hearings.

Refer to appeals section from the Policy Support\Operational and Procedure. The Policy Support operational and procedure is located at IME universal/operational procedures/medical services/Policy Support.doc.

Performance Standards: N/A

Forms/Reports:
N/A

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:
N/A

MED-Prior Authorization Urgent Request

Purpose: The review coordinator (RC) will discuss with their manager and log the request.

Identification of Roles:

Review Coordinator (RC) –enter urgent care request in Individualized Services Information System and urgent request tracking log.

Manager- Report the number of urgent care requests and timeliness quarterly to corporate URAC compliance staff.
Director- Ensure the percent of timely urgent request are reported on the URAC compliance dashboard quarterly.

Path of Business Procedure:

Step 1: Urgent requests for prior authorization of services will be reviewed and a decision rendered and communicated in no less than 72 hours from receipt of the request.
Step 2: A request is urgent if the situation poses an immediate threat to the health and safety of the Medicaid member or if the attending physician, member or family member indicates that the need is urgent. This time frame includes holidays and weekends.
Step 3: When an urgent request is received, the staff member will confer with manager and log the request on the spreadsheet located at MedSrv/Urgent Requests/Urgent Request Tracking.

Form/Reports:

Urgent Request Tracking

Program	Review Coordinator	Member L. Name	Member F. Name	SID	Requestor	Initial Date of Service	Date & Time of Request	Decision	Date & Time of Decision	No. of rs.	Notes

RFP Reference:

N/A

Interfaces:

N/A

Attachments:

N/A

MED Prior Authorization Internal Quality Control Reports

Purpose: To provide continuous quality improvement to the PA functions, meet all performance standards and complete all required reports. Internal Quality Control (IQC) activities will be conducted regarding inter-rater reliability.

Identification of Roles:

Manager - Tracks and reports performance standards, update manual and complete reports.

Quality Improvement Facilitator – Assists manager in tracking and reporting performance standards. Coordinates IQC for the team.

Performance Standards:

Monthly tracking measures will confirm the following performance standards:

- Processing of 95 percent of complete PA requests not requiring PR within ten business days.
- Processing 95 percent of complete PA requests requiring peer review within 15 business days.
- Processing 95 percent of PA requests requiring additional information within 60 days of initial receipt and not denied prior to 45 days of initial receipt if information is not received.

Path of Business Procedure:

Step 1: The manager will track and report all performance standards in a format approved by DHS.

Step 2: The manager will implement monthly tracking measures.

a. Any problem trends will be addressed through process and/or workflow changes designed to reverse the trend and avoid a problem before it impacts a performance standard.

Step 3: The Manager will access reports through the following link: http://dhsmoss1/ime/bltc/Reports/Forms/AllItems.aspx

Step 4: Each month by the third business day, the manager will confirm that the following reports are available by selecting each report in the menu and clicking build report.

a. PA Procedure Codes by Member
b. PA Procedure Codes by Provider
c. PAs – Approved (includes Units and Dollar Value)
d. PAs – Denied (includes Denial Reason)

Step 5: The manager will confirm completion of the PA Timeliness tracking report by designated support staff.

Step 6: The excel Book for the fiscal year is located in MedSrv/PA-EPSDT-TCM/Reports/PA/PA Timeliness/FYxxxx. The manager will prepare a monthly timeliness report in the following steps:

a. Copy current month into a new spreadsheet
b. Delete Month column
c. Replace all fields of #DIV/0! With *** to indicate that a calculation is not available for that
particular field
d. Ensure all headers are bold and words are listed with breaks only at syllables
e. Select Page Setup, select Landscape, add header of PA Timeliness, Month, Year
f. Rename Sheet PA Timeliness Month2008; delete extra sheets
g. Select Print area for report
h. Ensure all columns are centered and font is correct
i. Review data for accuracy

Step 7: Save completed report in IMEUniversal/MED SRV SUBMITTED REPORTS/Prior Authorization/FYyyyy, PA Timeliness MM-YYYY.

Step 8: Send e-mail to all associated DHS Policy specialists as follows replacing dates with current dates:

The following monthly report has been placed on IME Universal.
The Prior Authorization Timeliness report for (Month) can be found at: IME Universal/Med Srv Submitted Reports/Prior Authorization/FY20YY/PA Timeliness 02-20YY

Step 9: The manager will confirm documentation of the above bulleted reports by accessing report tracking as follows: Medsrv_rpt on 'Dhsime, Required Reports Tracking, yyyy.

Step 10: On the PA page, Manager will enter the due date for each report which is the tenth business day of the month.

Step 11: The manager will enter the date the above reports were verified in Data Warehouse and the date that the PA Timeliness Report was posted on IME Universal.

Step 12: The manager will complete hard copy of Monthly PA Scorecard located in IMEUniversal/MED SRV SUBMITTED REPORTS/Administrative/Monthly Performance Measures/YYYY based on review of the above performance measures. Manager will provide designated Program Assistant with hard copy of monthly report.

Forms/Reports:

PRIOR AUTHORIZATION IQC FORM

PA TYPE: LETTER ID OF REVIEWER:

PA NUMBER: MONTH:

REVIEW GUIDELINE QUESTION	YES	NO	COMMENTS
1. Was appropriate documentation available for review?			

2. Are notes and coding on the PA form consistent with current policies?			
3. Were redactions done appropriately?			
4. Was the review forwarded to physician/consultant appropriately?			
5. Did comments in box 25/29 on PA form adequately reflect rationale for denial or modification?			
6. Was MMIS updated correctly based on the review completed?			
7. Do you agree with the decision based on the information provided?			

Interfaces:
Data Warehouse
MMIS
OnBase

RFP Reference:
6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

Attachments:
N/A

MED Prior Authorization Disruption of Business Plan

Purpose: To provide procedures for the continuation of business in the event of inability to utilize electronic programming.

Identification of Roles:

Review Coordinator (RC) – responds to PA requests, verifies eligibility and enters data elements on PA spreadsheet. All activities will be noted on the manual-tracking log

Review Assistant (RA) - receives PA request, enters on spreadsheet, routes to the appropriate RC and sends notices to providers as needed. All activities will be noted on the manual-tracking log

Manager – provides direction, training and oversight in PAs

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 days of receipt of the request.

- Complete 95 percent of PA) requests not requiring physician review enter into system and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

Path of Business Procedure:

Step 1: The RA will receive PA request via fax or mail.
Step 2: Upon receipt of the PA request on form 470-0829, the RA and/or RC will assign a PA number in Box 12 on the form composed of a unique ten-digit number composed of the last digit of the year, three-digit Julian date, a two-digit PA type number and a four-digit document number (YJJJPA####).
Step 3: The RA and/or RC will enter the following data in PA paper tool:

a. Date Received
b. RC
c. PA Number
d. PA Type
e. Date Span
f. Provider Number
g. Provider Name
h. Member ID #
i. Member Name
j. Date out for Additional Information
k. Dates of Nudge Requests
l. Date Additional Information Returned
m. Date Sent To Consultant
n. Date of Nudge for Consultant
o. Date Returned from Consultant

p. Time spent by the consultant
q. Disposition
r. Comments

Step 4: The RA and/or RC will forward PA request to the appropriate RC.
Step 5: The RA and/or RC will complete eligibility and medical review as outlined in PA procedures.
Step 6: The RA and/or RC will complete additional information requests and physician/consultant reviews utilizing form templates in Microsoft Word.
Step 7: The RA and/or RC will complete modification or denial NODs utilizing form templates in Microsoft Word.
Step 8: The RC will enter data elements 10-18 on the PA paper tool.
Step 9: The RC will return adjudicated PA request form to RA.
Step 10: The RA will fax or mail completed PA request form and NODs (if applicable).
Step 11: The RA will file paper copies of PA Request form by provider name.
Step 12: The RA will enter data in WPM tool when system returns to function.

Forms/Reports:

PA Paper tool

Interfaces:

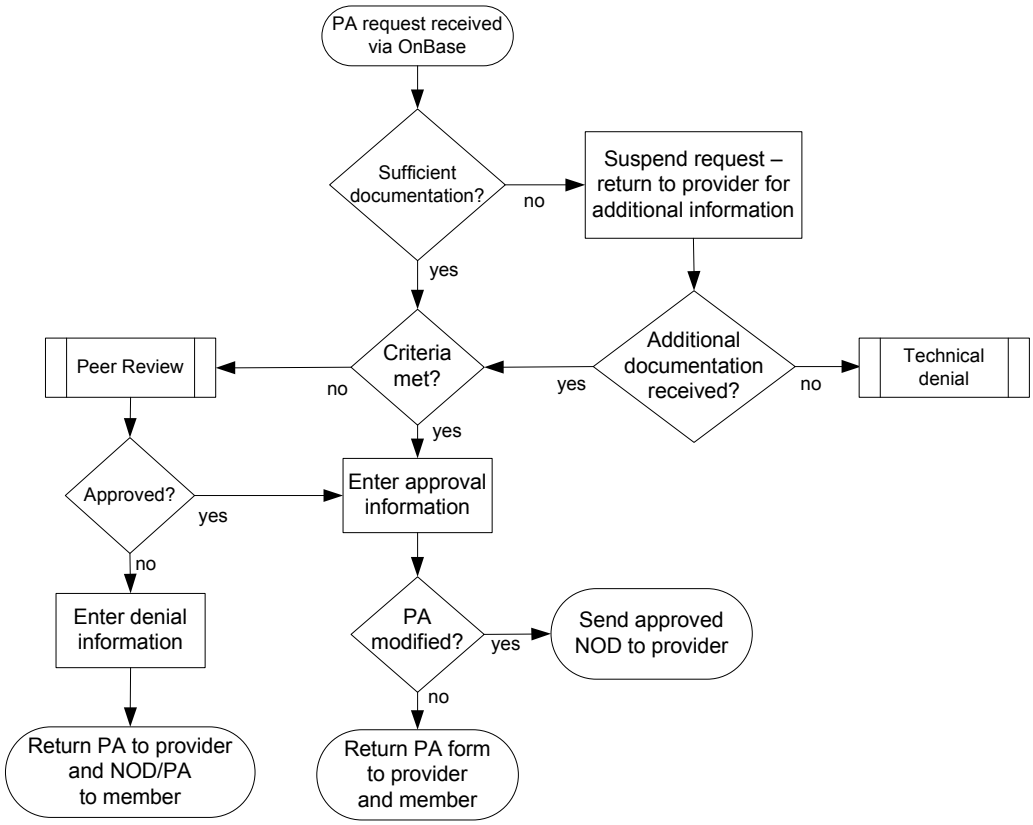
Data Warehouse
MMIS
OnBase

RFP Reference:

6.2.5
6.2.5.1
6.2.5.2
6.2.5.3

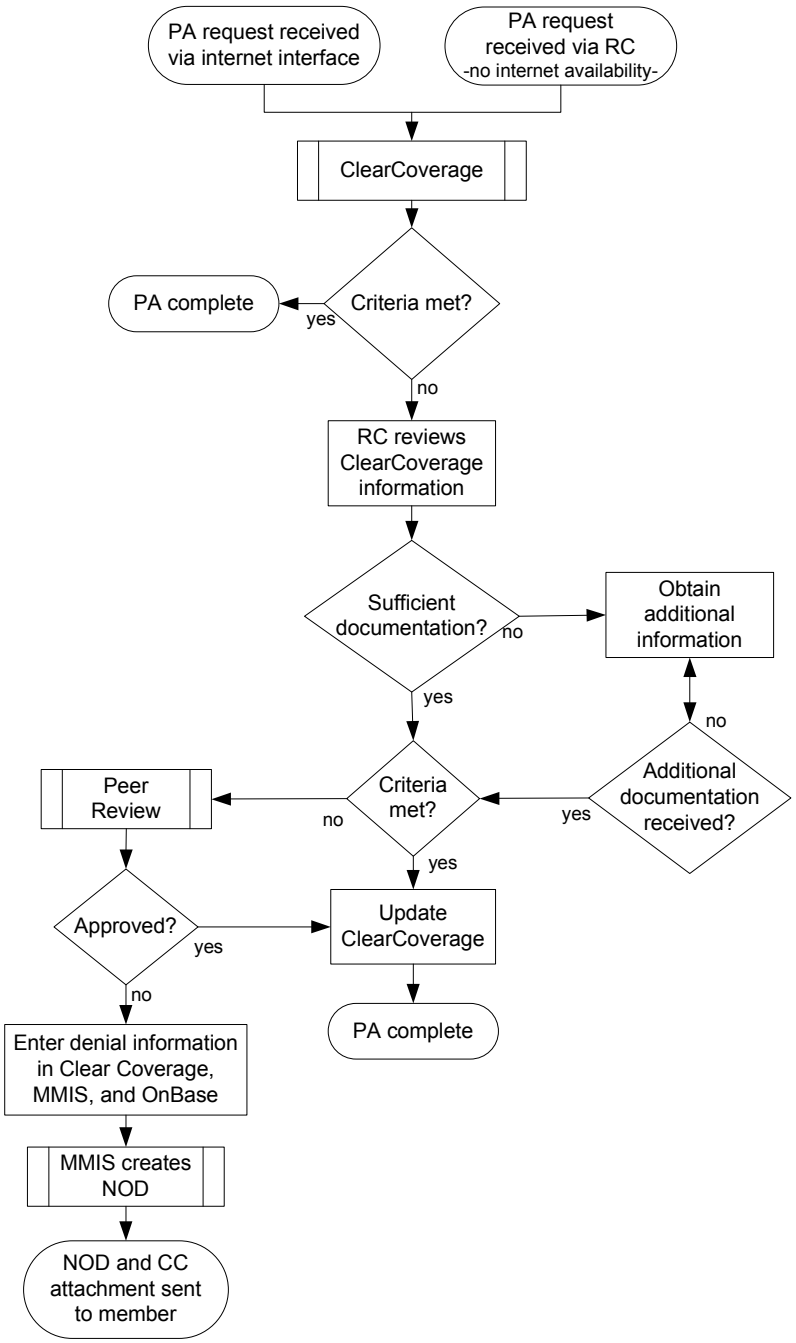
Attachment A:

Prior Authorization



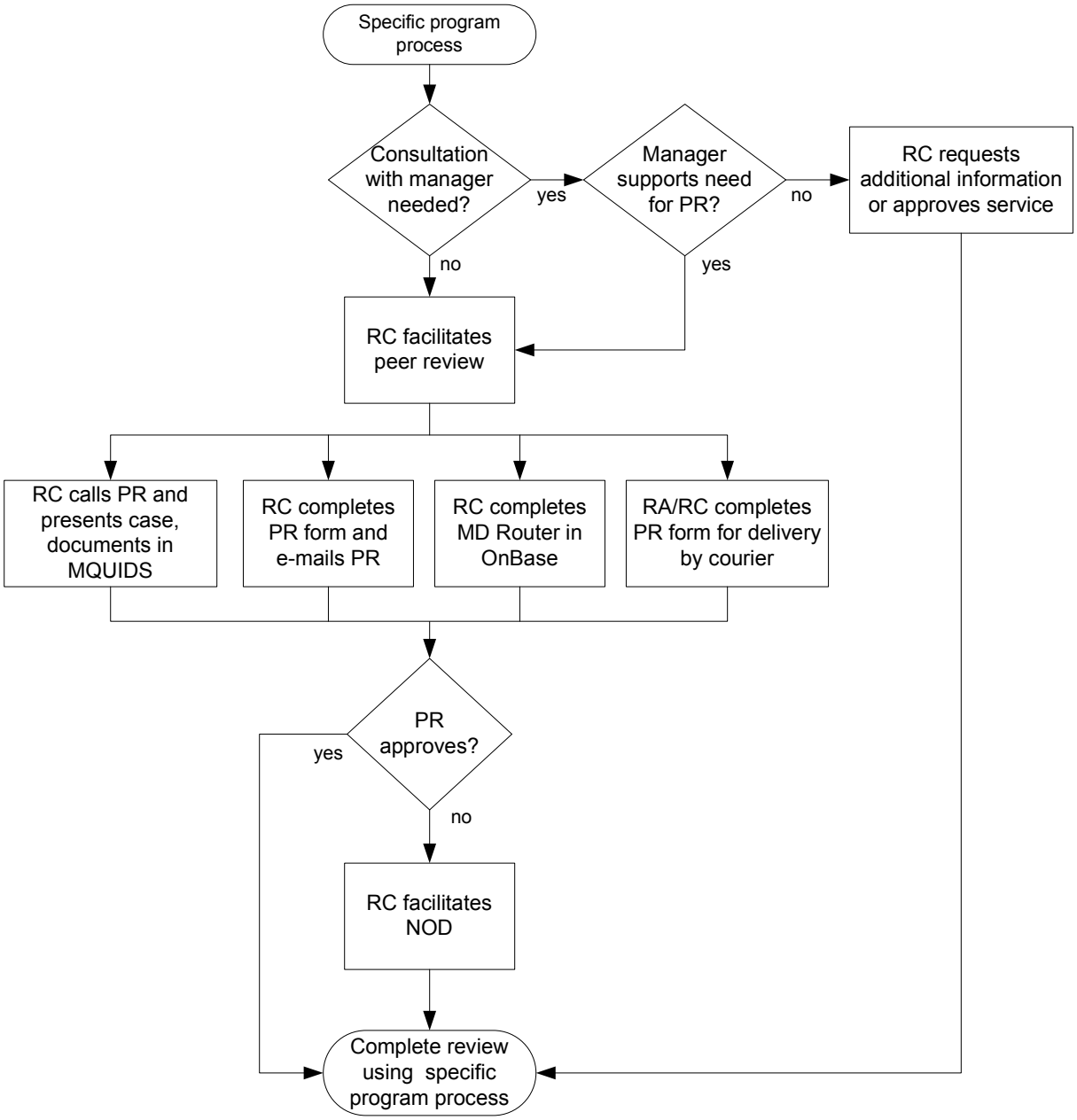
Attachment B:

Prior Authorization of Imagery – Clear Coverage



Attachment C:

Peer Review



Attachment D: